Associates In Surgery
Authorization for Disclosure of Health Information

1. I hereby authorize Associates in Surgery, PA to disclose/obtain the following information from the Provider health records of

_____ _____
Patient's Name Date of Birth

The records to be disclosed cover the following period(s) of health care:

_____ _____
From date To Date

Records to be obtained from: _____

2. Information to be disclosed

[] Complete health records	[] Discharge summary	[] History & Physical Examination
[] Consultation reports	[] Progress notes	[] Laboratory tests
[] X-ray reports	[] Vascular Studies	
[] Other _____		

I understand that this will include information relating to (check if applicable):
[] Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus.
[] Psychiatric care
[] Treatment for alcohol and /or drug abuse

3. This information is to be disclosed/obtained from _____

_____

For the purpose of _____.

4. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Rhonda Mizelle, Privacy Contact at Associates in Surgery, PA, P O Box 1880, Conway, SC 29528/or providers privacy contact. I understand that a revocation is not effective to the extent that Associates in Surgery, PA/provider has relied on the use or disclosure of the protected health information.

6. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

7. Associates in Surgery, PA will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

8. I understand that I have the right to:
   - Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent state law provides greater access rights.)
   - Refuse to sign this authorization.

9. The use of disclosure requested under this authorization may result in direct or indirect remuneration to Associates in Surgery, PA from a third party.

10. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signed (patient) Date

_____ _____
Legal Representative Relationship Date

_____ _____
Witness Date